

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4781

CERTIFICATE OF DEATH

04767
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton RFD Greensboro</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS <u>None 05K-2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>August P. Brogley</u>				4. DATE OF DEATH Month Day Year <u>April 24 1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 7 1877</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>France</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>August P. Brogley</u>				14. MOTHER'S MAIDEN NAME <u>Josephine KIRRHoff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-36-0232</u>			
17. INFORMANT <u>Lena Brogley Greensboro, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral arterial insufficiency</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign prostatic hypertrophy; obstructive uropathy</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>Unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>4-24</u> 19 <u>59</u> , to <u>4-24</u> 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St. Easton Md.</u> DATE SIGNED <u>4-27-59</u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Boulaie</u>				ADDRESS <u>Greensboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

11703

CERTIFICATE OF DEATH

1981

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Cause of death		9. Place of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of witness		14. Signature of funeral director		15. Signature of undertaker	
16. Signature of coroner		17. Signature of medical examiner		18. Signature of pathologist		19. Signature of toxicologist		20. Signature of other	
21. Signature of other		22. Signature of other		23. Signature of other		24. Signature of other		25. Signature of other	
26. Signature of other		27. Signature of other		28. Signature of other		29. Signature of other		30. Signature of other	
31. Signature of other		32. Signature of other		33. Signature of other		34. Signature of other		35. Signature of other	
36. Signature of other		37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
41. Signature of other		42. Signature of other		43. Signature of other		44. Signature of other		45. Signature of other	
46. Signature of other		47. Signature of other		48. Signature of other		49. Signature of other		50. Signature of other	
51. Signature of other		52. Signature of other		53. Signature of other		54. Signature of other		55. Signature of other	
56. Signature of other		57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other		65. Signature of other	
66. Signature of other		67. Signature of other		68. Signature of other		69. Signature of other		70. Signature of other	
71. Signature of other		72. Signature of other		73. Signature of other		74. Signature of other		75. Signature of other	
76. Signature of other		77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other		85. Signature of other	
86. Signature of other		87. Signature of other		88. Signature of other		89. Signature of other		90. Signature of other	
91. Signature of other		92. Signature of other		93. Signature of other		94. Signature of other		95. Signature of other	
96. Signature of other		97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	

1

ALABAMA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4801

CERTIFICATE OF DEATH

04768

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sherwood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 34</u>				e. STREET ADDRESS <u>Box 34</u>			
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>B</u> Last <u>Brooks</u>				4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/28/1895</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Brook</u>				14. MOTHER'S MAIDEN NAME <u>Sarah McKenney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs. Mary Brooks, Sherwood, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>252.0 Congestive Heart Failure</u> DUE TO (b) <u>Thyroid Heart Disease</u> DUE TO (c) <u>2-3yr</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/10/59</u> 19 <u>59</u> , to <u>10 April</u> 19 <u>59</u> , that I last saw the deceased alive on <u>10 April</u> 19 <u>59</u> , and that death occurred at <u>5:50 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Randall Watts, M.D.</u> M.D.				DATE SIGNED <u>4-12-59</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Sherwood Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James R. Radwell</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 1 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

CERTIFICATE OF DEATH

01

1910

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH
01
1910

NAME OF DECEASED: *Charles H. Smith*
AGE: *45*
SEX: *Male*
DATE OF DEATH: *Jan 15 1910*
PLACE OF DEATH: *At home*
CAUSE OF DEATH: *Heart Disease*
DISEASE OR INJURY: *Myocarditis*
PERIOD OF ILLNESS: *One week*
PLACE OF BIRTH: *Boston, Mass.*
DATE OF BIRTH: *Dec 10 1864*
MARRIAGE: *Married*
OCCUPATION: *Teacher*
EDUCATION: *High School*
RELIGION: *Protestant*
BURYAL: *St. Paul's Church*
SIGNATURE OF PHYSICIAN: *Dr. J. H. Smith*
SIGNATURE OF REGISTRAR: *Wm. H. Smith*

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4802

CERTIFICATE OF DEATH

04769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Falbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Falbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>		c. LENGTH OF STAY IN TB <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXFORD</u> d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Brooks</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/21/65</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Georgeanne Nixon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Perry Brooks Jr. Oxford, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease.</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/21</u> , 19 <u>58</u> , to <u>4/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/7</u> , 19 <u>59</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>12 N. HANSON</u> DATE SIGNED <u>4/7/59</u> ACTUAL SIGNATURE <u>L. J. Eglseider</u> M.D. <u>L. J. Eglseider</u> PHYSICIAN'S NAME (Type) <u>EASTON, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>4/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Oxford Cem.</u>		<u>Oxford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell, Easton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

CERTIFICATE OF DEATH

2005

STATE OF NEW YORK - DEPARTMENT OF HEALTH

11/17/05

DATE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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4803

CERTIFICATE OF DEATH

04770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal oak</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal oak</u>	
c. LENGTH OF STAY IN TB <u>Life</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Francis Brummell</u>		4. DATE OF DEATH Month Day Year <u>4 2 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/21</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MURRAY R. Brummell</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>129-26-2325</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 443X DUE TO <u>Anteriorly located Cardiovascular 10 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 Nov 59</u> , 19 <u>59</u> , to <u>2 April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1 April</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Rene U. Roth</u> M.D.		ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md.</u> DATE SIGNED <u>4-6-59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Royal oak Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Daniel</u> ADDRESS <u>Porter, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and no event within 72 hours after death.

1913

CERTIFICATE OF DEATH

03

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1868		New York City	
Cause of Death		Disease		Symptoms		Time of Death		Place of Death	
Heart Disease		Myocardial Infarction		Chest pain, shortness of breath		Jan 15, 1913		New York City	
Occupation		Education		Marital Status		Religion		Signature of Physician	
Teacher		High School		Married		Catholic		[Signature]	
Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

CHIEF OF BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04771

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Talbot rural St. Michaels c. LENGTH OF STAY IN 1b 1 yr.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ida L. Bryant 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 30, 1873 9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR: Months Days Hours Min.			4. DATE OF DEATH Month Apr. 30, Day 19 Year 59		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY housewife		
11. BIRTHPLACE (State or foreign country) CANADA			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME John W. Davis			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mr. Thompson Roth			Address Oxford, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic cardiovascular DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile changes - marked.					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-23- 19 58 to 4-30 19 59 , that I last saw the deceased alive on 4-30 19 59 , and that death occurred at 1:45 p. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5-1-59 DATE SIGNED					
ACTUAL SIGNATURE Dr. Guy M. Reeser, Jr. M.D.					
PHYSICIAN'S NAME (Type) Dr. Guy M. Reeser, Jr. St. Michaels, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1959		22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery	
22d. LOCATION (City, town, or county) (State) Oxford, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son			
ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE MAY 4 1959		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4782

CERTIFICATE OF DEATH

104772
Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNE</u>	
c. LENGTH OF STAY IN 1b <u>10 DAYS</u>		d. STREET ADDRESS <u>SUDLERSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MILLARD</u> Middle <u>OTHO</u> Last <u>BULL</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 25, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROAD FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STATE ROADS</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OTHO BULL</u>		14. MOTHER'S MAIDEN NAME <u>ALICE STIFFLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-1808</u>	
17. INFORMANT <u>Wife</u> Address <u>SUDLERSVILLE, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lymphatic leukemia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Esophagus - color - gastroscopy</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-30</u> , 19 <u>59</u> , to <u>4-9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 19</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) <u>219 S. Washington St. 94108</u> DATE SIGNED <u>April 9, 1959</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or other) (State)
<u>Burial</u>	<u>April 12, 1959</u>	<u>Sudlersville Cem.</u>	<u>Sudlersville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Pellos</u> ADDRESS <u>Mullington Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles A. Blank</u>	



4783

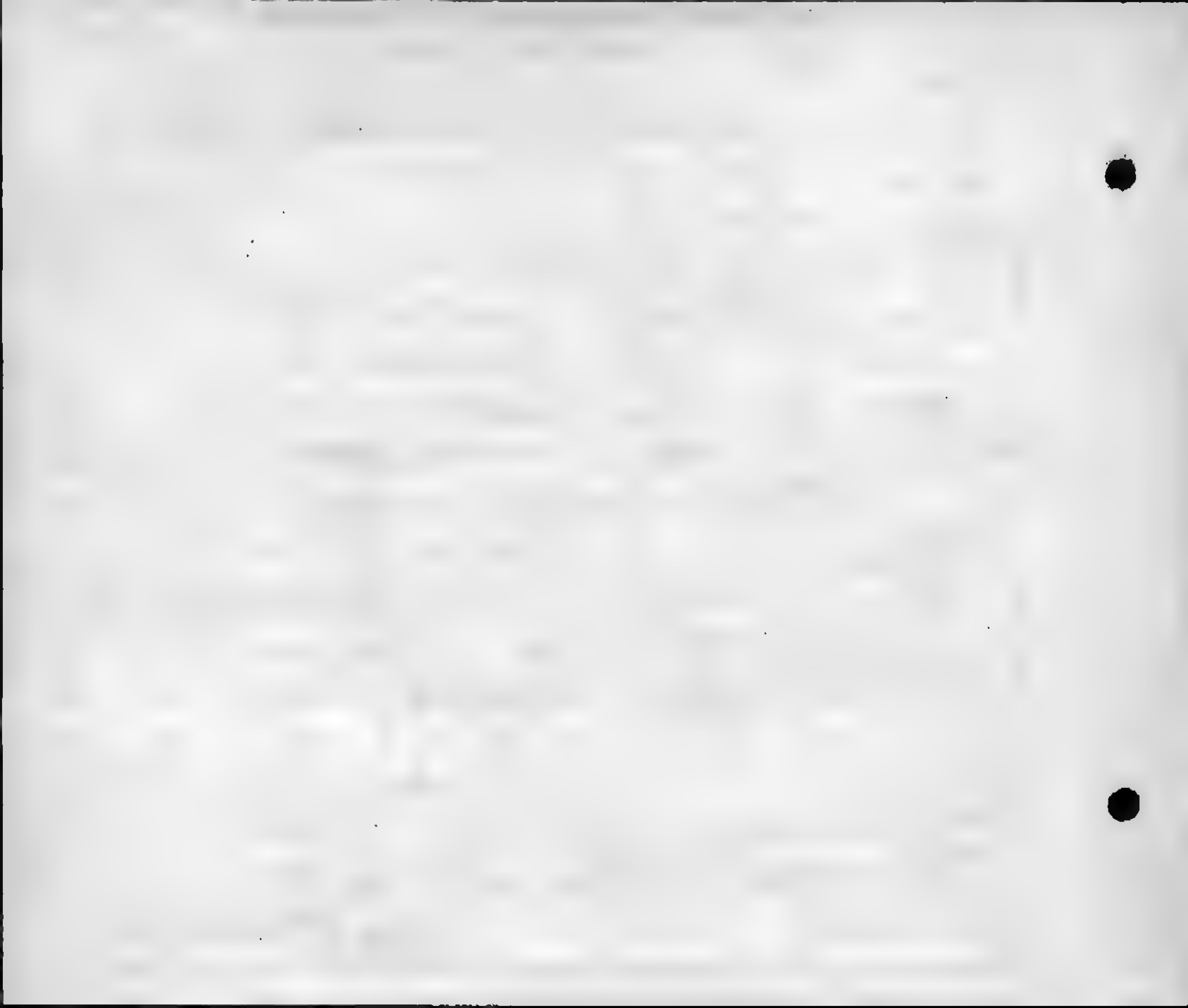
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.		d. STREET ADDRESS 209 S. 6th St. 05 X	
3. NAME OF DECEASED (Type or print) (Mrs) Annie V. Collison		4. DATE OF DEATH 4-17-1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 23, 1872 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Choe		14. MOTHER'S MAIDEN NAME Rebecca Tankard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Rebecca Collison		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left lower lobe pneumonia 490 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Fractured pelvis 2) Senility			INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/15 , 19 59 , to 4/17 , 19 59 , that I last saw the deceased alive on 4/17 , 19 59 , and that death occurred at 2:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 202 Dover St. DATE SIGNED 4-20-59			
ACTUAL SIGNATURE Robert W. Trever M.D.		22. PHYSICIAN'S NAME (Type) ROBERT W. TREVER Easton Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 19, 1959	
22c. NAME OF CEMETERY OR CREMATORY Denton		22d. LOCATION (City, town, or county) (State) Denton Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Moore ADDRESS Denton		24a. REC'D BY REGISTRAR DATE APR 24 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Thayer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4805

Item 9 R11MG242 5-6-59 et

CERTIFICATE OF DEATH

04774
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whittman				c. LENGTH OF STAY IN b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. d. STREET ADDRESS Whittman			
3. NAME OF DECEASED (Type or print) First John Middle R Last Cooper				4. DATE OF DEATH Month 4 Day 18 Year 1959			
5. SEX M	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/ Approx.	9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Oyster		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME John Westley Cooper				14. MOTHER'S MAIDEN NAME Mary Hynson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mary E. Cooper Whittman, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis. DUE TO Compensatory peripheral vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis (b) Arteriosclerosis (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 5 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1958 to April 1959 , that I last saw the deceased alive on April 19, 1959 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James B. Dashiell M.D.				ADDRESS (Street, city or town, state) TILGHMAN DATE SIGNED 12/24/59			
PHYSICIAN'S NAME (Type) GUY M. PRESEER SR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/59		22c. NAME OF CEMETERY OR CREMATORY Richards Cem.		22d. LOCATION (City, town, or county) (State) Easton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell ADDRESS Easton, Md.				24a. REC'D BY REGISTRAR DATE APR 27 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hume	

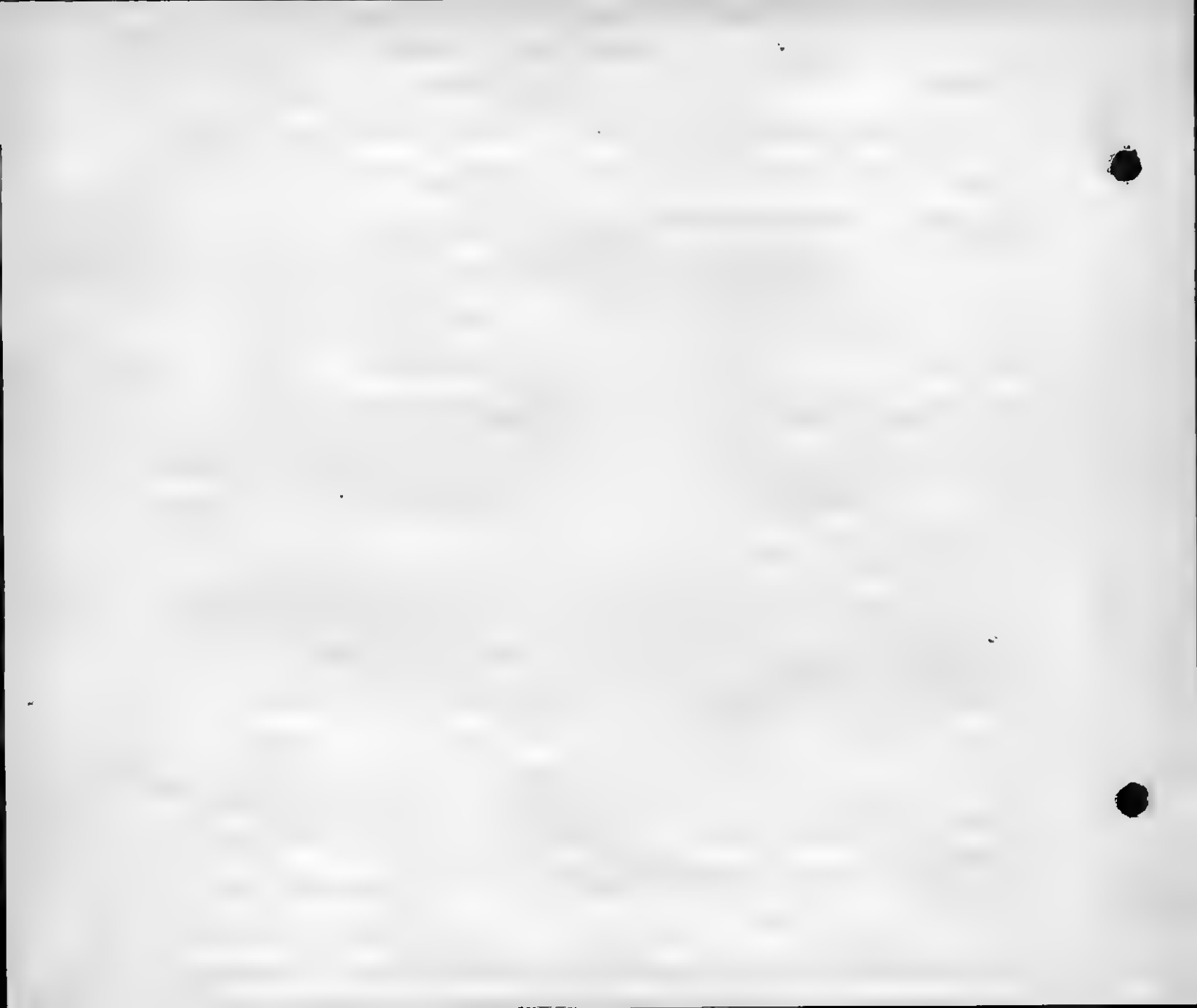


4784

CERTIFICATE OF DEATH

04775
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Tulbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Tulbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN 1b <u>35 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1 419 South Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Elizabeth Foster</u>				4. DATE OF DEATH Month Day Year <u>April 1 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs. <u>60</u>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HW</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Ellen Johns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intre. pontine hemorrhage</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Nephrosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>219 S. Washington St Easton Md.</u> ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D. <u>2 Apr 59</u> PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u> <u>Easton 16, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richardson</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James P. Delaney</u>				ADDRESS <u>Easton 7th</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>			



04777

1. PLACE OF DEATH a. COUNTY <u>St. Michael's</u>		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> <u>17X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rd Vista Nursing Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>SADIE</u> First <u>B</u> Middle <u>CAFFORD</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27 - 1873</u>
9. AGE (in years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>St Michaels Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George Edwin Brown</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Salerni</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Susan H. Barnett, 3018 Madison Ct W.D. Del.</u>		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b) and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Dis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>4 mos</u> <u>5 mon</u> <u>10 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 April</u> , 19 <u>59</u> , to <u>7 April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6 April</u> , 19 <u>59</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md</u> DATE SIGNED <u>7 April</u> ACTUAL SIGNATURE <u>R. Lane Wroth, M.D.</u> PHYSICIAN'S NAME (Type) <u>R. LANE WROTH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>April 10 - 59</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Chesterfield</u>		<u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm Earl Barton, Barton Bros Centerville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kenna</u>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4785

CERTIFICATE OF DEATH

04778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>IAH-T</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>121607</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>121607</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edward H. HALLAWAY</u>				4. DATE OF DEATH <u>4-27</u> 19 <u>59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1, 1887</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. E. Hallaway</u>				14. MOTHER'S MAIDEN NAME <u>Annie Bassett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u> </u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u>50</u> , to <u>4/27</u> , 19 <u>59</u> that I last saw the deceased alive on <u>4/27</u> , 19 <u>59</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>P. E. Cox</u> M.D. <u> </u>				PHYSICIAN'S NAME (Type) <u>DOCTOR P. E. COX M.D.</u> <u>EASTON, MARYLAND</u>			
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF <u>April 30, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Offord Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Offord Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman & Son Easton Md.</u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

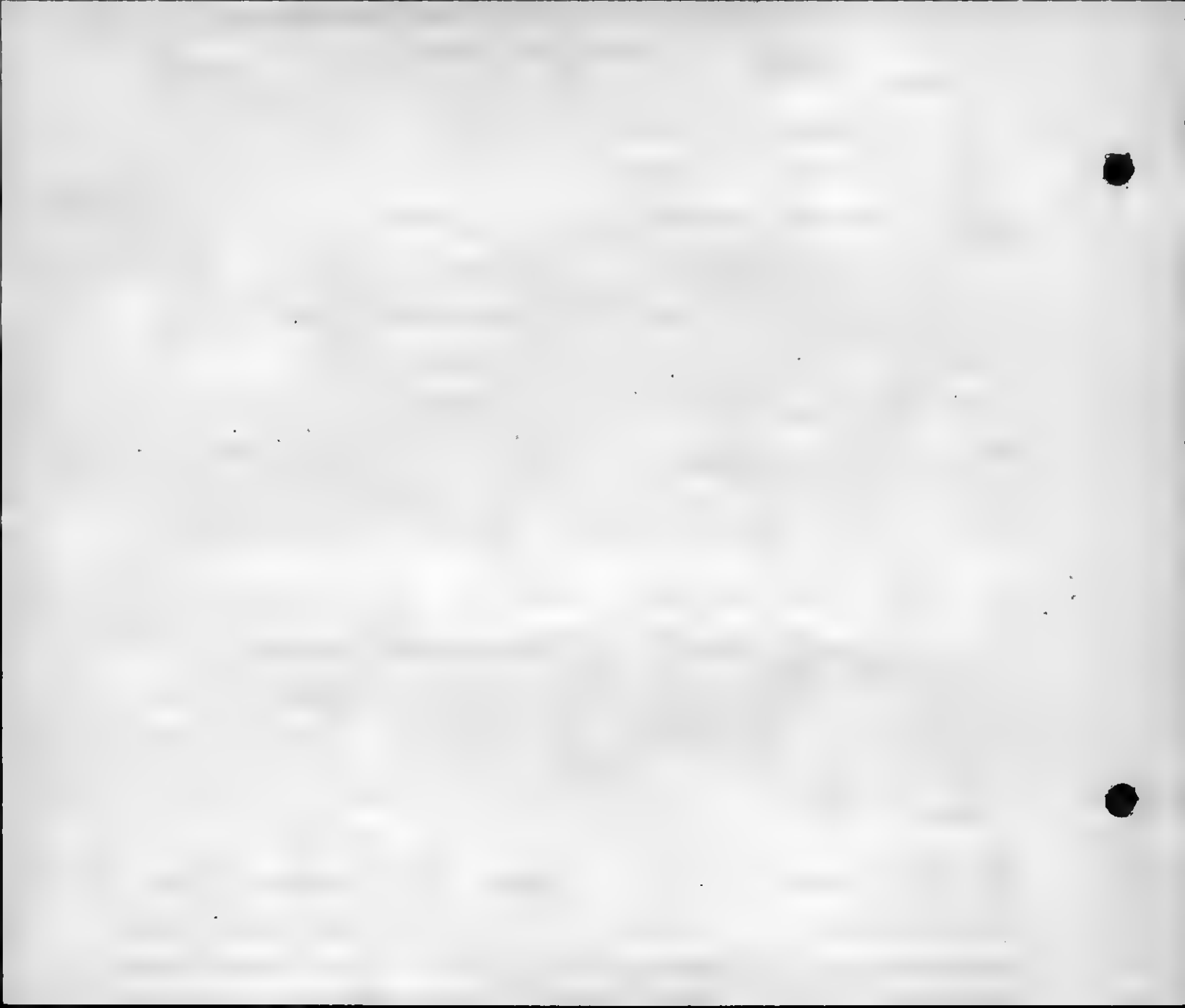
4786

CERTIFICATE OF DEATH

Reg. Dist. No.

04779

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eustis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eustis Memorial Hospital</u>				d. STREET ADDRESS <u>3723-38th Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>S.</u> Last <u>Harris</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 20, 1898</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book-Binder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph S. Harris</u>				14. MOTHER'S MAIDEN NAME <u>Bridget Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Joseph Wm. Harris, Son</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Hypertensive cardiac insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> 19 <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 April</u> , 19 <u>59</u> , to <u>13 April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12 April</u> , 19 <u>59</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>K. Harris</u>				DATE SIGNED <u>13 April 1959</u>			
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>APR 16 '59</u>				DATE <u>—</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4787

CERTIFICATE OF DEATH

04780
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Albot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henderson</u> 05X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>B</u> Last <u>Medford</u>				4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 7, 1893</u> 86 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seed Mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Miller</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Medford</u>				14. MOTHER'S MAIDEN NAME <u>JANE WYNTH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>280-32-0190</u>		17. INFORMANT <u>Roy Medford Henderson, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-H-D</u> 4-2-7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/20</u> , 1957, to <u>4/7</u> , 1959, that I last saw the deceased alive on <u>4-7</u> , 1959, and that death occurred at <u>11:28</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Md.</u> DATE SIGNED <u>P.E. COX</u>							
ACTUAL SIGNATURE <u>P.E. COX</u> M.D.				PHYSICIAN'S NAME (Type) <u>P.E. COX</u> <u>Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Boulaie</u> ADDRESS <u>Greensboro, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Wright</u>	



4788

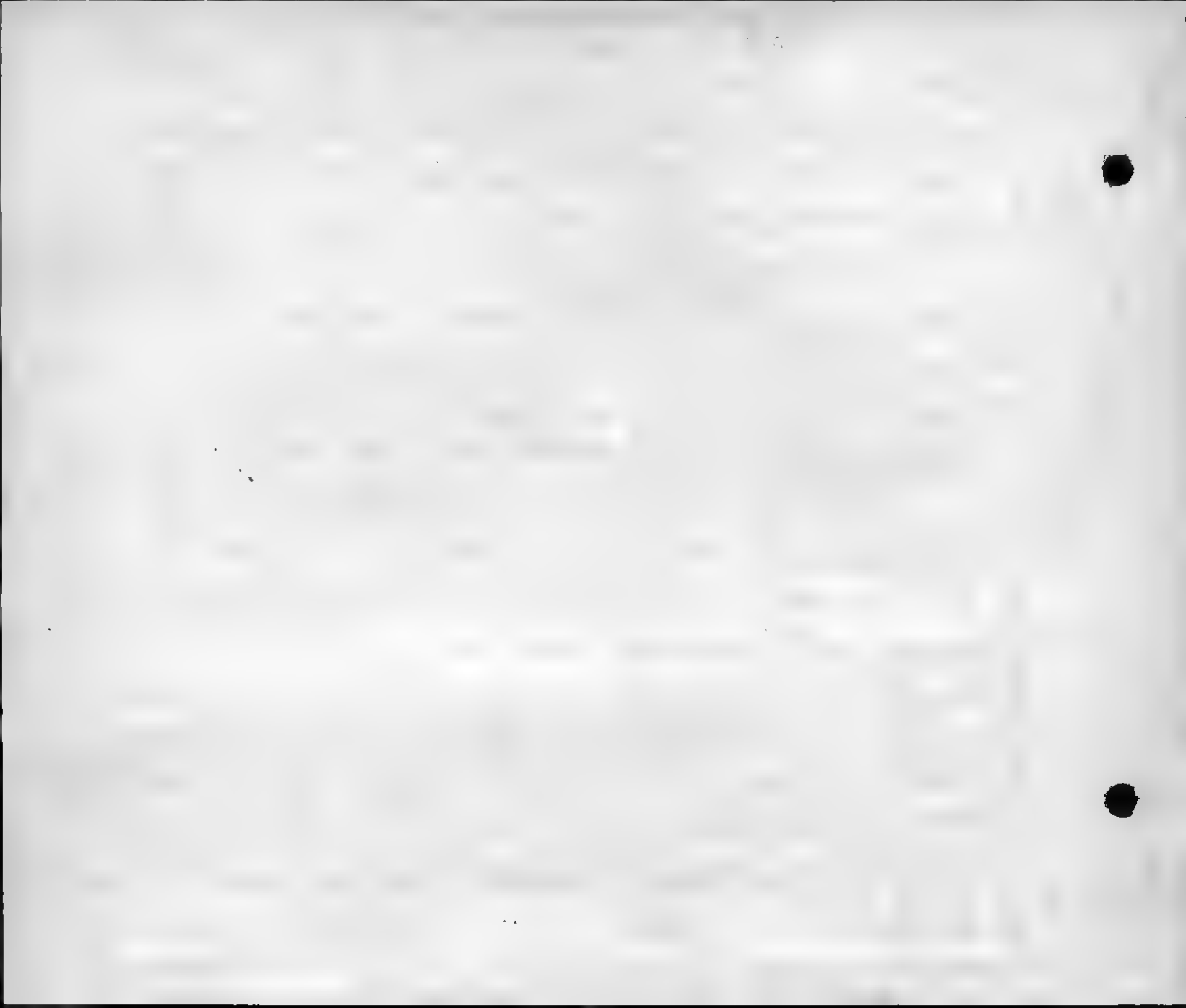
CERTIFICATE OF DEATH

04781

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HENDERSON</u>	
c. LENGTH OF STAY IN 1b <u>32 hr.</u>		d. STREET ADDRESS <u>None</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>L</u> Last <u>MELVIN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 23 1879</u>
9. AGE (in years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Melvin</u>		14. MOTHER'S MAIDEN NAME <u>Susan Reed</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-28-1298</u>	
17. INFORMANT <u>Julia Melvin Henderson</u>		Address <u>md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>490X</u> DUE TO <u>Memorial Tobacco Co.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>490X</u> DUE TO <u>490X</u> (c) <u>490X</u> DUE TO <u>490X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2-14-D</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>EASTON, MD</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>P. E. Cox</u> M.D. <u>EASTON, MD</u>			
PHYSICIAN'S NAME (Type) <u>P. E. Cox</u> <u>EASTON, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Cox</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit receipt. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

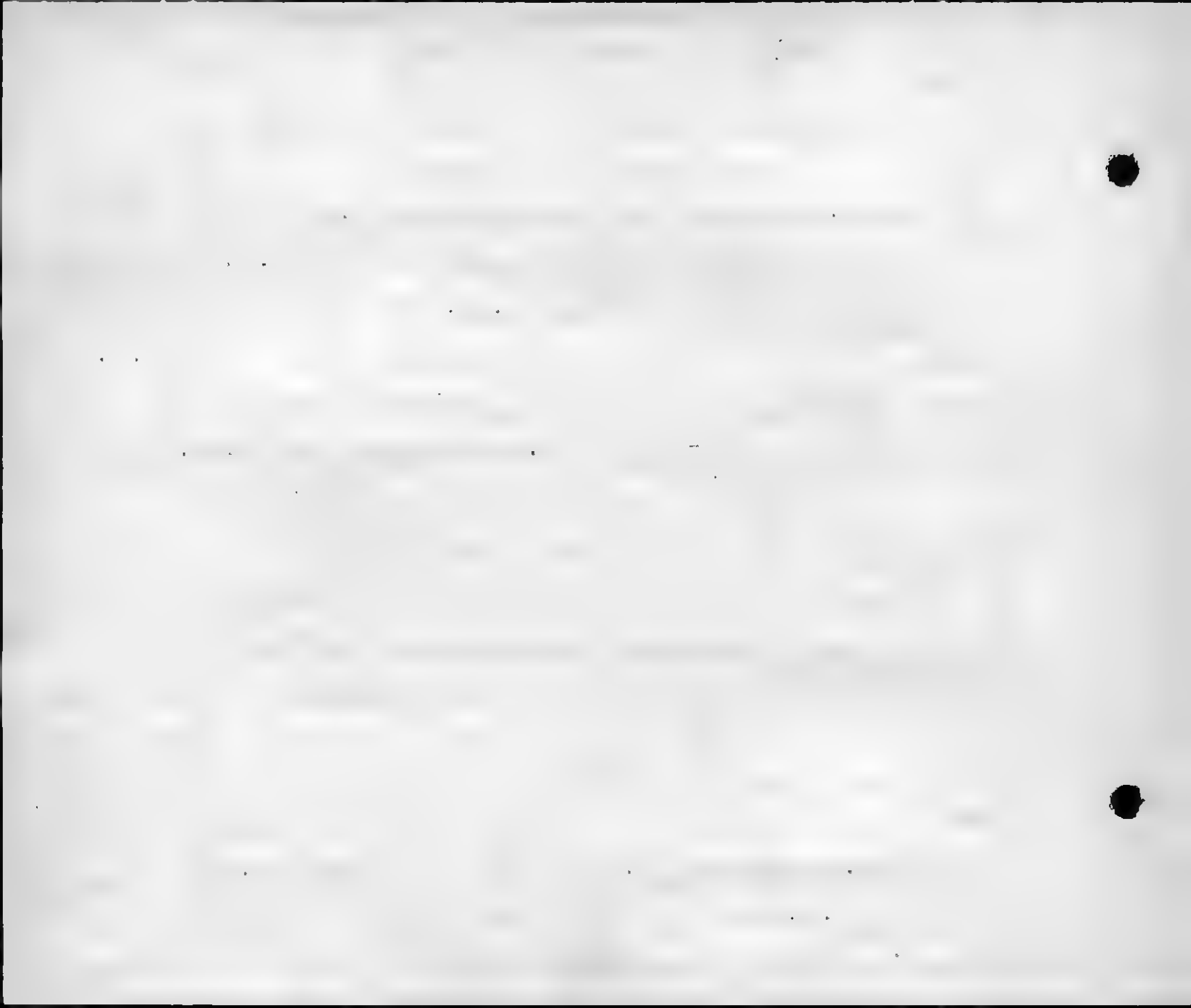


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4789 CERTIFICATE OF DEATH

04782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 Aurora St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle LEWIS Last MULLIKIN				4. DATE OF DEATH Month Apr. Day 5 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1879	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Louis Mullikin				14. MOTHER'S MAIDEN NAME Louisa Winterbottom			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-34-9755		17. INFORMANT Mr. Arlie Mullikin Address Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Prostate DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 years 2+ years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 7/11, 1957 , to 4/4, 1959 , that I last saw the deceased alive on 4/4, 1959 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Md.							
ACTUAL SIGNATURE Shepherd		M.D.		DATE SIGNED 4/7/59			
PHYSICIAN'S NAME (Type) Dr. Shepard Krech, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 8, 1959	22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Maryland		24a. REC'D BY REGISTRAR APR 13 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kline		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or reburial, and in any event within 72 hours after death.

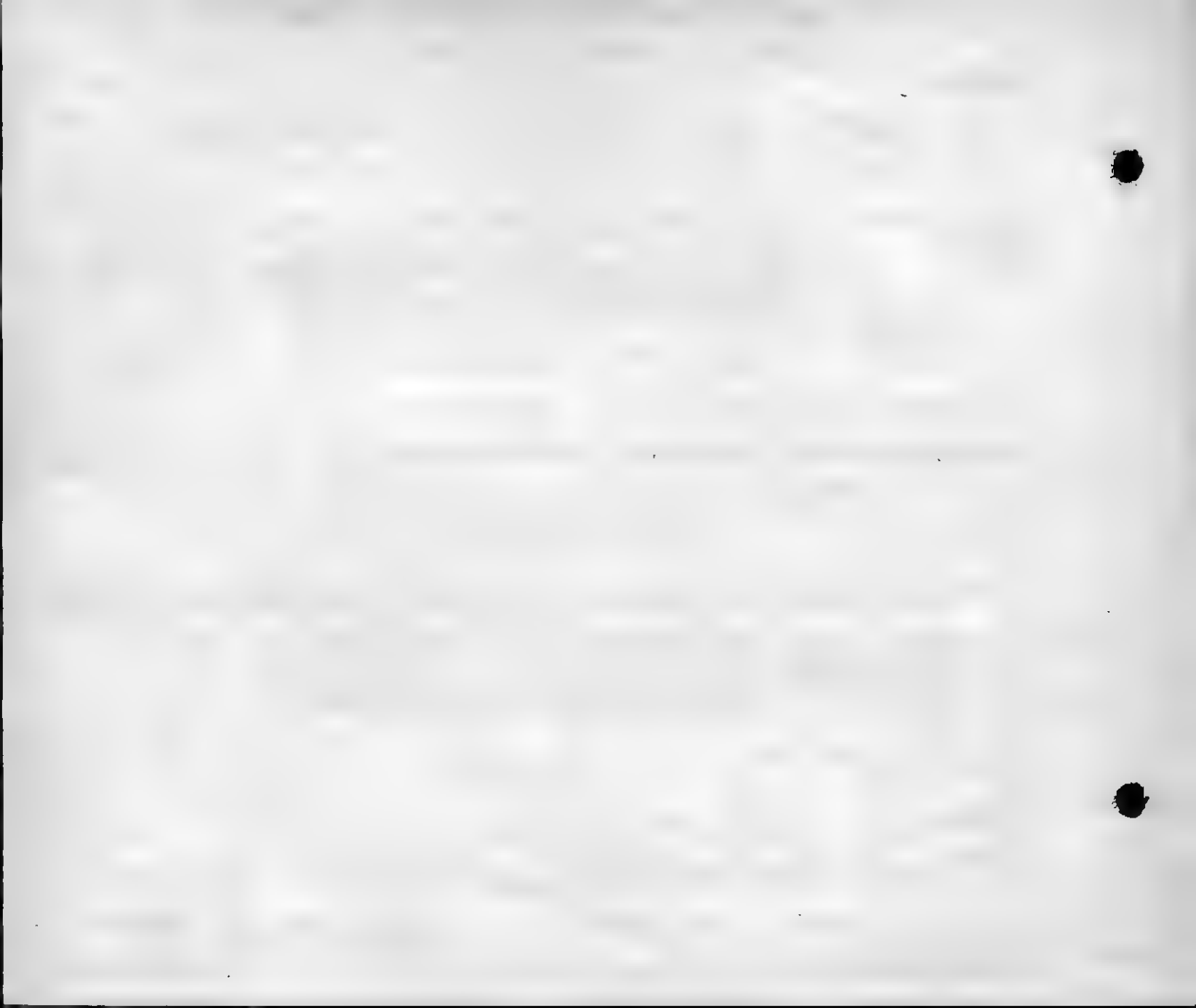
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4790

CERTIFICATE OF DEATH

104783
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Omer</u> Middle <u>O'Donnell</u> Last <u>O'Donnell</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 8, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boatman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing & Logging</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas O'Donnell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Horney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>218-16-8174</u>	
17. INFORMANT <u>Walter C. Horner</u>		Address <u>Grasonville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> DUE TO (b) <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1959</u> Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		DATE SIGNED <u>APR 11 1959</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS <u>Easton, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APR 11, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>	22d. LOCATION (City, town, or county) (State) <u>St Ignace, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler, Jr. of Butler Bros., Centerville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Horner</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4791

Item 3 filed 5-1-59 at

CERTIFICATE OF DEATH

Reg. Dist. No.

04784

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>R.</u> Last <u>Ciehlrich</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15 1895</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refuse of</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Refuse of</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Herman Ciehlrich</u>			
14. MOTHER'S MAIDEN NAME <u>Rita Schick</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>10-11-47</u>				17. INFORMANT <u>Mrs. Gary R. Ciehlrich, Easton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Acute pyelitis</u> (c) <u>Pyelonephritis</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Easton</u>				20g. (County) <u>Talbot</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				DATE SIGNED <u>2195. West 11-9 107 ST. 25/4-59</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 27, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) <u>Easton</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. H. H.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>G. H. H. H.</u>	



4792

CERTIFICATE OF DEATH

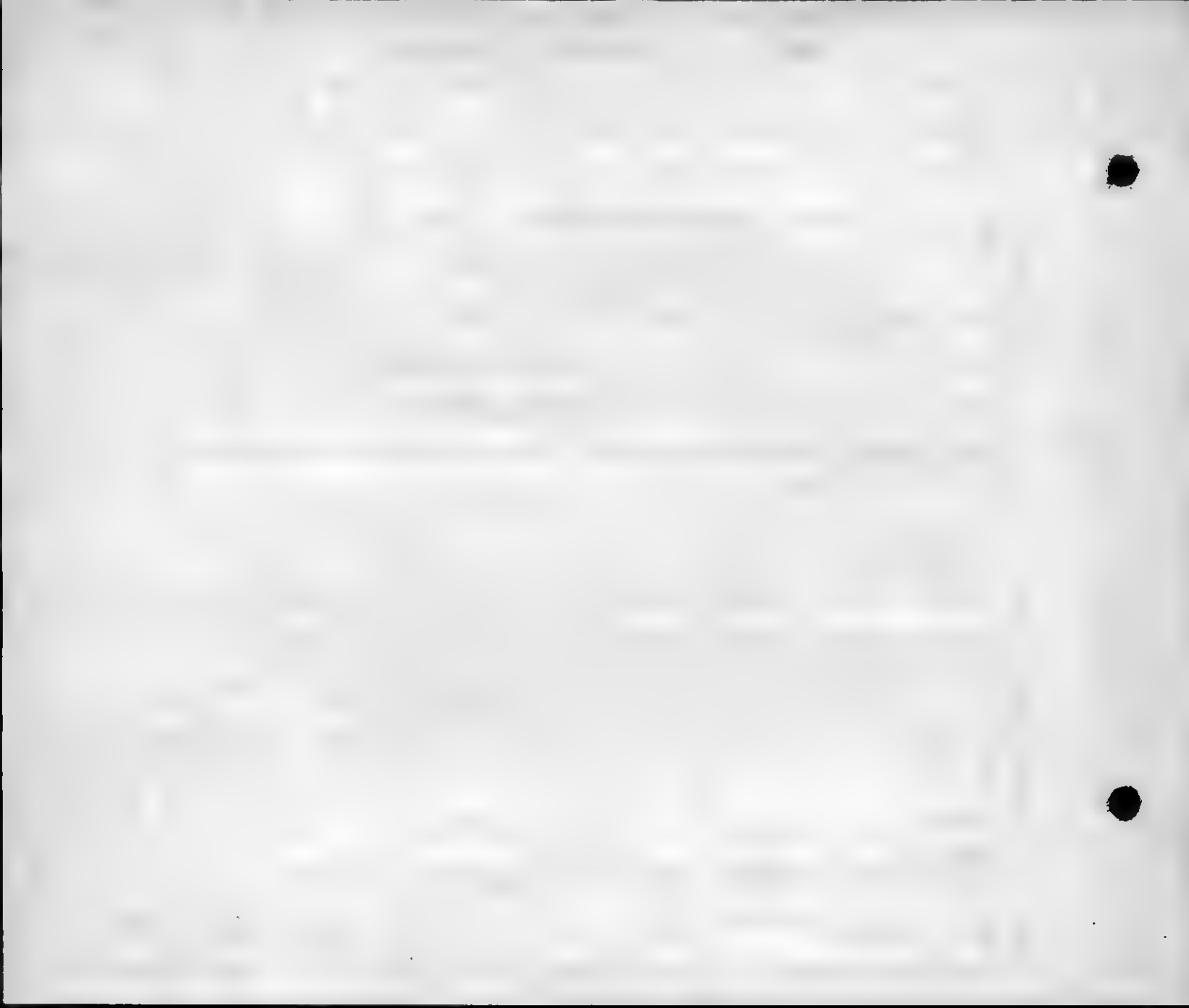
04785

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TA/lot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>TA/lot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Pastor</u> Last <u>Pastor</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 5, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Steen</u>		14. MOTHER'S MAIDEN NAME <u>Harriet P. Parsons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>5 years</u> (c) <u>Diabetes Mellitus</u> DUE TO <u>10 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Heart Fail</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>29 March, 1959</u> to <u>4 April, 1959</u> , that I last saw the deceased alive on <u>Apr 4</u> , 1959, and that death occurred at <u>12:55</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Lane Wroth</u> M.D.		ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md</u> DATE SIGNED <u>4-5-59</u>	
PHYSICIAN'S NAME (Type) <u>R. LANE WROTH MD</u>		<u>Box 487 - St. Michaels, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam</u>		ADDRESS <u>Easton Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	
DATE <u>APR 13 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

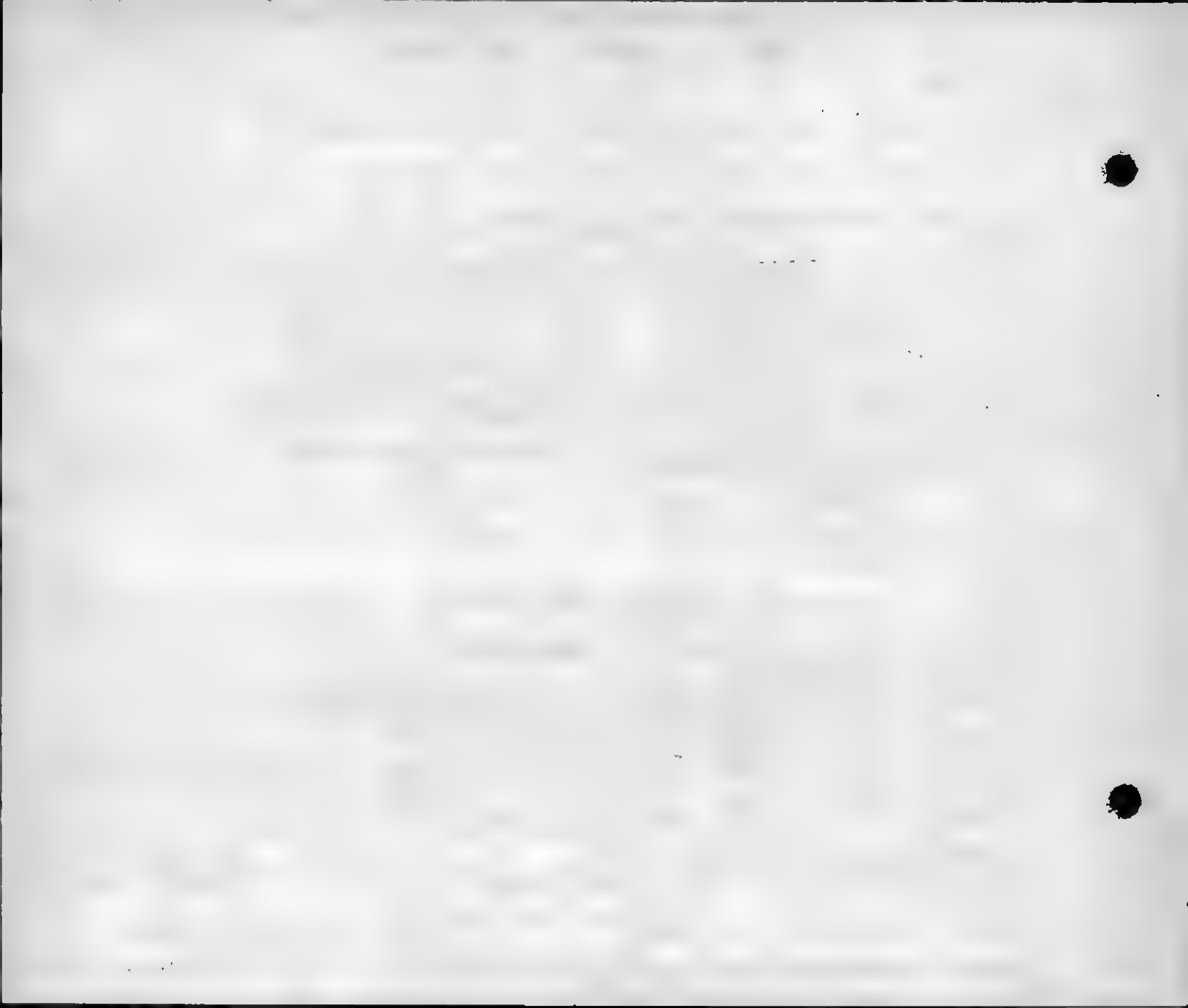
4793

CERTIFICATE OF DEATH

Reg. Dist. No.

04786

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY in 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>Marvin</u> Last <u>Pastorfield</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 16, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster - Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mr. Philip Pastorfield</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Layfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u> <u>UKA</u>		16. SOCIAL SECURITY NO. <u>UKA</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emphysema</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic mitral valvulitis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:35</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		DATE SIGNED <u>219 S. West 11th St. 13 April 59</u>	
PHYSICIAN'S NAME (Type) <u>Easton Md. Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Currell</u>		ADDRESS <u>EASTON, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 11-11-11 4-4-5-1 et

4807

CERTIFICATE OF DEATH

04787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wittman</u>		c. LENGTH OF STAY IN 1b <u>2 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bother's home</u>		d. STREET ADDRESS <u>Sherwood</u>	
3. NAME OF DECEASED (Type or print) <u>MARY Belle Pinder</u>		4. DATE OF DEATH <u>April 15 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 1929</u>
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William C. Warner</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-266189</u>	
17. INFORMANT <u>Wilson Pinder, Sr.</u>		Address <u>Sherwood, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> DUE TO <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO <u>hypertension</u> (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 15 1959</u> to <u>April 15 1959</u> , that I last saw the deceased alive on <u>April 15 1959</u> , and that death occurred at <u>11:00</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Ann.</u>		22d. LOCATION (City, town, or county) (State) <u>Sherwood Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Lockhill, Boston, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 21 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

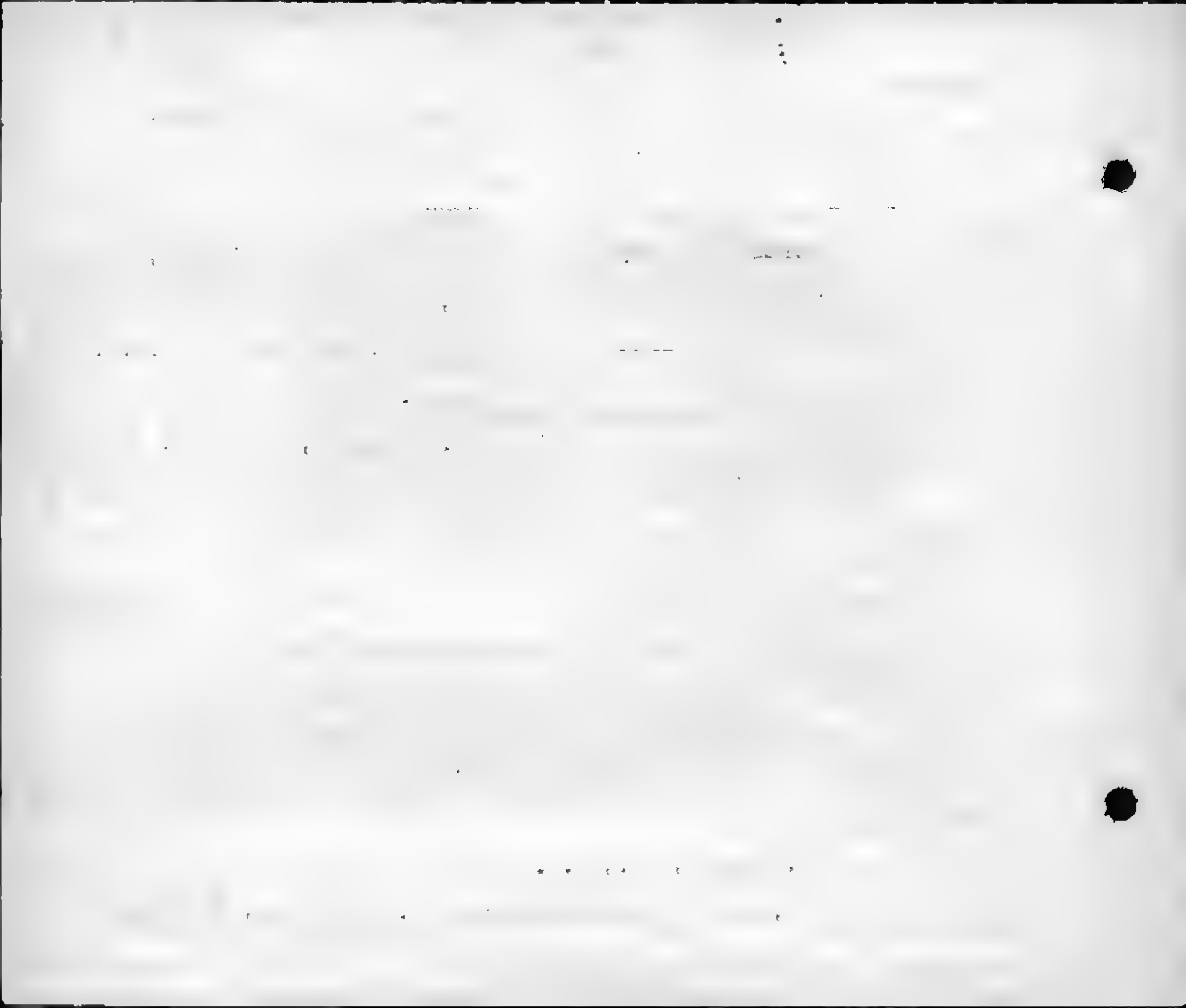
4808

CERTIFICATE OF DEATH

04788
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman				c. LENGTH OF STAY IN lb Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) ETHEL First JOYCE Middle REYNOLDS Last				4. DATE OF DEATH Month April Day 26 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1918	
9. AGE (In years last birthday) 40 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tilghman, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Ruthford Haddaway			
14. MOTHER'S MAIDEN NAME Clara M. Gibson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Jimmie W. Reynolds, Tilghman, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer Liver & Intestines of Liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 2, 1959 , to April 26, 1959 , that I last saw the deceased alive on April 26, 1959 , and that death occurred at 3:40 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Guy M. Reesor, Sr., M.D.							
PHYSICIAN'S NAME (Type) Guy M. Reesor, Sr., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 29, 1959		22c. NAME OF CEMETERY OR CREMATORY Tilghman Memorial Cem.		22d. LOCATION (City, town, or county) (State) Tilghman, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS St. Hampton Harrison St. Michael's							
24a. REC'D BY REGISTRAR DATE APR 30 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4794

CERTIFICATE OF DEATH

04789

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 618 South Street		d. STREET ADDRESS 1 618 South Street	
3. NAME OF DECEASED (Type or print) First Middle Last Ida Mae Satchell		4. DATE OF DEATH Month Day Year April 29 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1880
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. FATHER'S NAME James R. Haddock		12. CITIZEN OF WHAT COUNTRY? USA	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		14. SOCIAL SECURITY NO none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) none		16. INFORMANT Mrs. J. Thomas Ozman, 108 South St. Easton, Maryland	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS-ABDOMINAL 1992 DUE TO PRIMARY VISCERAL SITE UNDETERMINED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from P. M., 19, to 19, that I last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5-1-59			
ACTUAL SIGNATURE Louis S. Welty		M. D. Easton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/2/59	22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	22d. LOCATION (City, town, or county) (State) Easton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Thompson		24a. REC'D BY REGISTRAR DATE MAY 5 '59	24b. REGISTRAR'S SIGNATURE William S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.



may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4795

CERTIFICATE OF DEATH

Reg. Dist. No.

04790

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>6 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>				d. STREET ADDRESS <u>RT. #1 Box 178</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>M.</u> Last <u>Schemm</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 19, 1902</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>2</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George F. Canlee</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ireland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-8539</u>		17. INFORMANT <u>Husband</u>		Address <u>Federalburg</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Anterior wall heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2-4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Essential hypertension</u> <u>2) Obesity</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-12</u> , 19 <u>59</u> , to <u>4-12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-12</u> , 19 <u>59</u> , and that death occurred at <u>4:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Robert W. Treven</u>				M.D. <u>207. Dover St.</u>			
PHYSICIAN'S NAME (Type) <u>Robert W. Treven</u>				Fellow M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 16, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BROOKLYN MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hampton Don</u>				ADDRESS <u>Federalburg md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. King</u>			



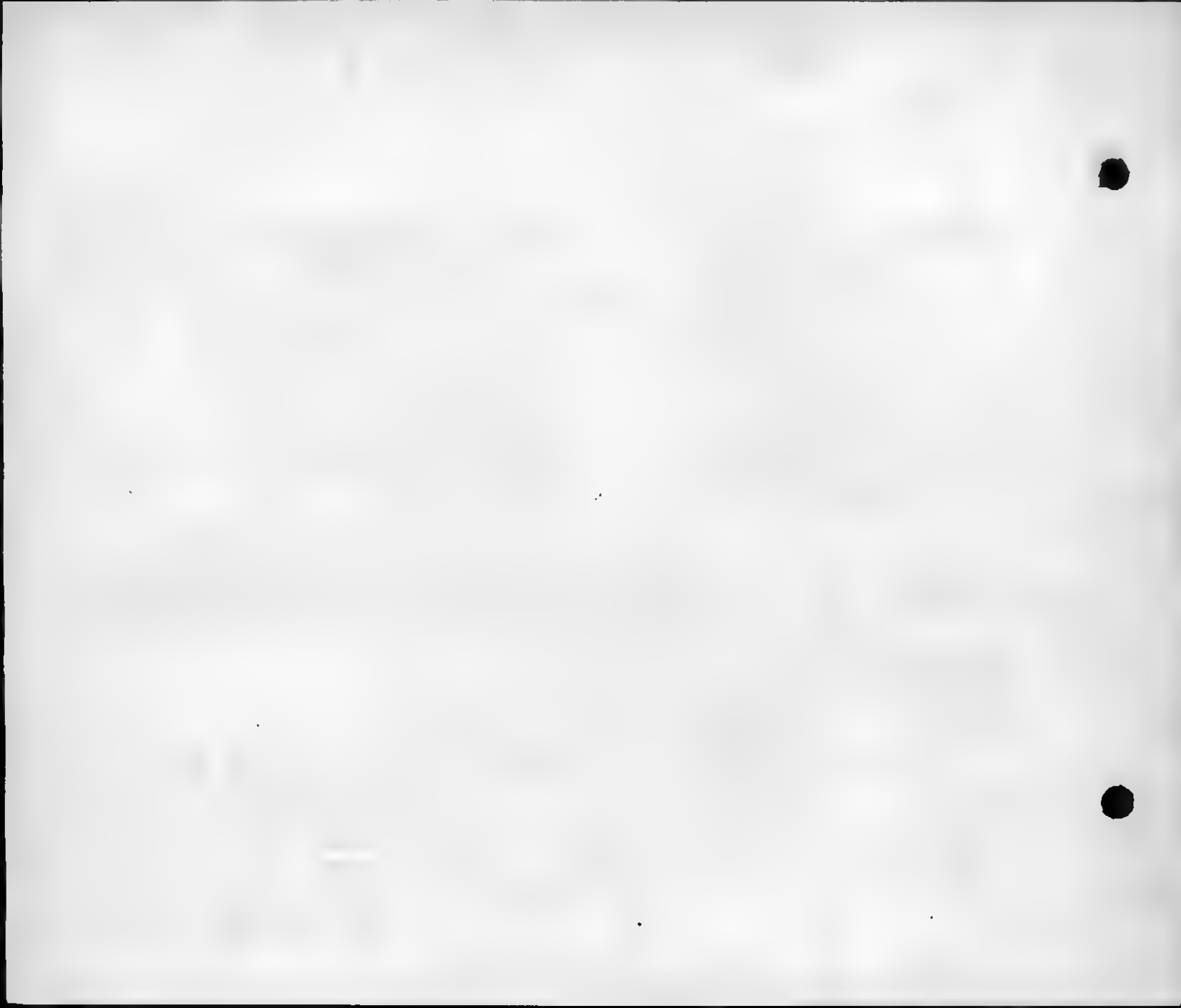
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4796 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04791
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u> 17x3	
c. LENGTH OF STAY IN 1b <u>4 1/2 hrs.</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thelma</u> Middle <u>V</u> Last <u>Schuyler</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1937</u>
9. AGE (in years last birthday) <u>21</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HW</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James A. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy L. Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-347814</u>	
17. INFORMANT <u>JAMES MOORE</u>		Address <u>CENTREVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>976x</u> DUE TO <u>Stress</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pistol shot right temple</u> DUE TO (c) <u>Wounds</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Self inflicted</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4</u> a. m. <u>2</u> p. m. <u>1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Stevensville</u> (County) <u>AN</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. F. McPherson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. F. McPherson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 5</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		22d. LOCATION (City, town, or county) <u>STEVENSVILLE</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u>		24a. REC'D BY REGISTRAR <u>APR 8 '59</u>	
ADDRESS <u>Church Hill Ind.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Lane</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4809 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04792

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write nearest town) <u>Easton RD</u> c. LENGTH OF STAY IN b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton RD</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Raymond</u> Middle <u>Sharp</u> Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		4. DATE OF DEATH <u>APR 1</u> Month <u>7</u> Day <u>19</u> Year <u>59</u> 9. AGE (In years last birthday) <u>66</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours M. n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MARDEN NAME <u>Martha Sharp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>World War I</u> 16. SOCIAL SECURITY NO <u>World War I</u> 17. INFORMANT <u>Mrs. Geneva Summers, Phila, Pa.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GSW-head</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>976X</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>GSW - pistol - star</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>7</u> Hour <u>10</u> a. m. <u>4-7-1959</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u> 20f. (City or town) <u>m Easton Tal</u> (County) <u>md</u> (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>L. M. WELTY</u> EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-5-59</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>4-11-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Preston, acm</u> 22d. LOCATION (City, town, or county) <u>Preston md</u> (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Clark, Easton, Md.</u> ADDRESS 24a. REC'D BY REGISTRAR <u>APR 14 '59</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, only in any event within 72 hours after death.

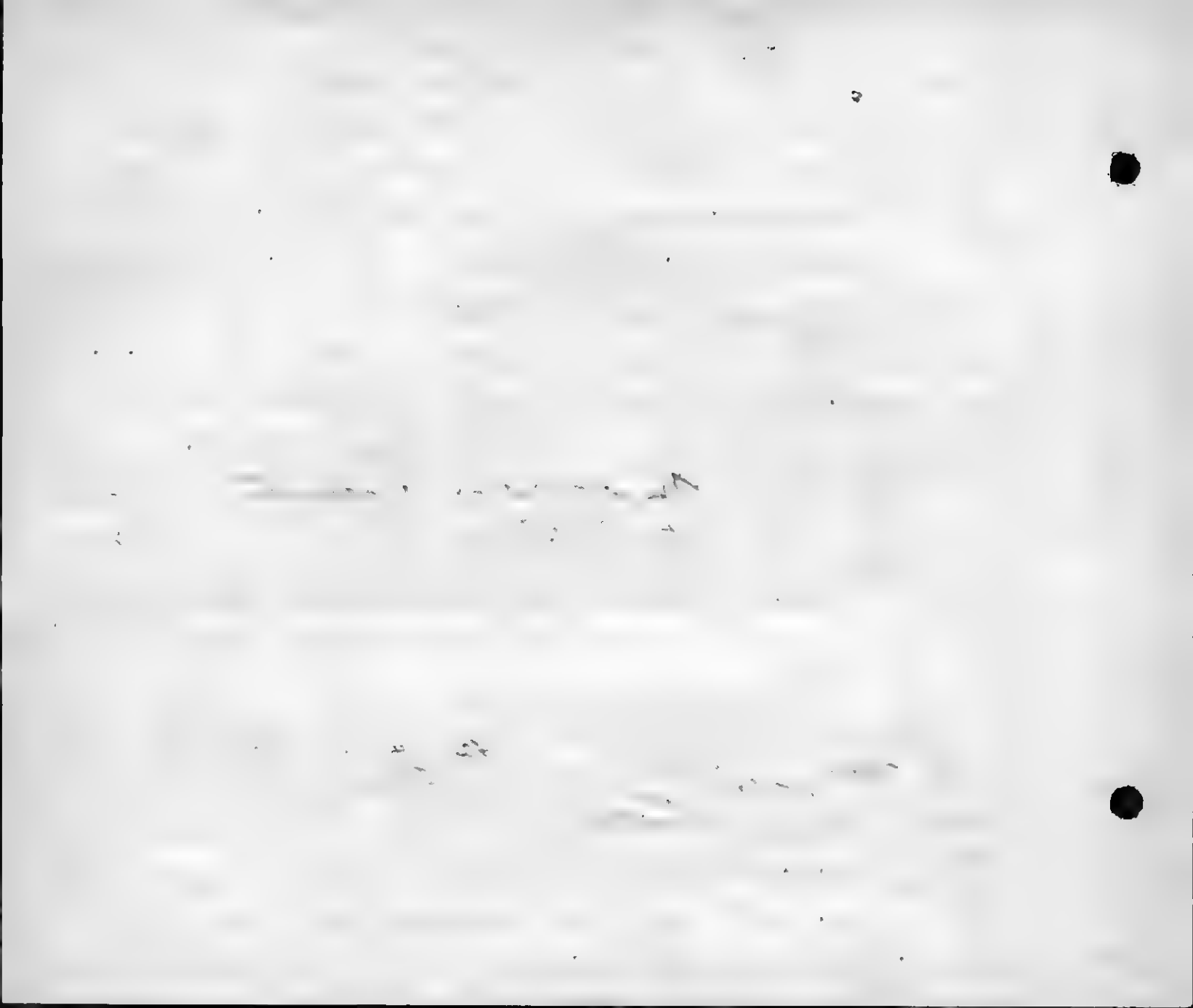
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4797

CERTIFICATE OF DEATH

04793
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN 1b 40 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 603 Goldsborough St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HELEN MAE Middle B. Last TOWNSEND				4. DATE OF DEATH Month Apr. Day 17, Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1894	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James S. Price				14. MOTHER'S MAIDEN NAME Mary Olivia Frazier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Everett Townsend Address Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) H.C.V.D. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1952 to 4/17/ 1959 , that I last saw the deceased alive on Feb 1, 1959 , and that death occurred at 3 45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE [Signature] M.D.							
PHYSICIAN'S NAME (Type) Dr. P. Evans Cox				Easton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 19, 1959		22c. NAME OF CEMETERY OR CREMATORY Windy Hill Cemetery		22d. LOCATION (City, town, or county) (State) Trappe (Rural) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE APR 22 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, within any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4798 CERTIFICATE OF DEATH

04794
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>T+ h +</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>T+ h +</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Epton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clin</u> Middle <u>F.</u> Last <u>Tull</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Richard F. Tull</u>	
14. MOTHER'S MAIDEN NAME <u>LARA Cox</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>451X</u> DUE TO <u>Believe not to be a heart attack</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) <u>2145 W. 11th St. Baltimore, Md.</u> DATE SIGNED <u>April 15 1959</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22. NAME OF CEMETERY OR CREMATORY <u>Edgemoor Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Frank</u> ADDRESS <u>1000 N. E. St. Baltimore, Md.</u>		24. REC'D BY REGISTRAR DATE <u>APR 15 '59</u>	
25. DATE THEREOF <u>April 16 1959</u>		26. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4799

CERTIFICATE OF DEATH

04796

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston - Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>05X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A</u> Last <u>Washington</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 4, 1887</u> 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saloon</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Washington</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>513-22-7888</u>		17. INFORMANT <u>Marybeth Sharp</u> Address <u>RD #2 Box 182 Preston, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Anemia</u> DUE TO <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Sehnemitt</u>				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, 16, Maryland.</u>			
DATE SIGNED <u>15 April 1959</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HARMONY Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Preston Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur & Thomas</u> ADDRESS <u>426 E. ...</u>				24a. REC'D BY REGISTRAR <u>APR 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4810

CERTIFICATE OF DEATH

04797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Bt. 3</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 146</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Easton,</u>			
				f. STREET ADDRESS <u>Box 146</u>			
3. NAME OF DECEASED (Type or print) <u>Rosalee</u> First <u>Wilson</u> Middle <u>Wilson</u> Last				4. DATE OF DEATH Month <u>4</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/15</u>		9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond Warner</u>				14. MOTHER'S MAIDEN NAME <u>Julia Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Charles Wilson</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>490X</u> DUE TO <u>Labor Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Same</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH _____
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>April 4</u> , 19 <u>59</u> to <u>April 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 6</u> , 19 <u>59</u> , and that death occurred at <u>Easton, Md.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Md.</u> DATE SIGNED <u>H. T. Webb</u>							
ACTUAL SIGNATURE <u>H. T. Webb</u> M.D.							
PHYSICIAN'S NAME (Type) <u>H. T. Webb</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ivytown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Talbot Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Carhill, Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Hume</u>	

CERTIFICATE OF DEATH

1913

10-10-13



Form with multiple horizontal lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4800

CERTIFICATE OF DEATH

04798

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Andersen</u> Middle <u>M</u> Last <u>Wood</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15, 1874</u>
9. AGE (In years less birthday) yrs. <u>85</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Wood</u>		14. MOTHER'S MAIDEN NAME <u>Anna Belle Morgan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Louise Harper Royal Oak Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Acute Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Benign Prostatic Hypertrophy</u> DUE TO (b) <u>610X</u> (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 weeks</u> <u>6 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>15 March</u> , 19 <u>59</u> , to <u>11 April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11 April</u> , 19 <u>59</u> , and that death occurred at <u>6 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Kane Wroth</u>		DATE SIGNED <u>Apr 15 59</u>	
PHYSICIAN'S NAME (Type)		ADDRESS	
22a. BIRTHAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 14, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WEST LAUREL HILL</u>		22d. LOCATION (City, town, or county) (State) <u>PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Keenan-John Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 15 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton L. Knapp</u>			

